Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Citizens with Developmental Disabilities

Informed Consent to Participate in the
Louisiana Money Follows the Person (MFP) Rebalancing Demonstration

PARTICIPANT SIGNATURE FORM

Purpose:
You are being asked to participate in the Louisiana Money Follows the Person (MFP) Rebalancing Demonstration (*My Place Louisiana*), a Medicaid program. The Demonstration will go on from May 1, 2007 through September 30, 2016. Eligibility for transition through the Demonstration is dependent upon residence in a qualified institution (nursing facility, ICF/DD, or hospital) and meeting criteria established in Louisiana's Operational Protocol.

This Demonstration will help you to move from an institution into a home and community-based living setting, such as a home or apartment. The move is called a "transition."

You will use the Demonstration to access services needed to live in the community. The state will use special funding for the first 12 months of services after transition. These 12 months are called the "Demonstration Period." After the Demonstration Period, your services will continue uninterrupted for as long as you need community services and remain Medicaid eligible.

This is a consent form. It gives details regarding the Louisiana Money Follows the Person (MFP) Rebalancing Demonstration. You are asked to sign this form if you wish to participate in the demonstration. Upon signing this form, you will be provided a copy of this form to keep in your records for reference.

Signature of Medicaid Recipient
I have read and understand the information provided above. I have been given an opportunity to ask questions. All of my questions have been answered to my satisfaction. I have been given a copy of this form as well as a copy of DHH's Notice of Privacy Practices. By signing this form, I willingly agree to participate in the Louisiana MFP Rebalancing Demonstration (*My Place Louisiana*) by:

1. Moving from the institution where I am living to a "qualified residence".
2. Choosing a qualified home and community-based service option that is a part of the Demonstration.
3. Sharing my information during the move planning process and after.

I understand that the state will keep protected Demonstration program records for years 2007 through 2016 that will include identifying information about me and the Medicaid services I use.

_____	_____	_____
Signature of Participant	Print Name	Date of Signature
_____	_____	_____
Signature of Legally Authorized Representative	Print Name	Date of Signature

Relationship to Participant (if signed by Legally Authorized Representative): _____

_____	_____	_____
Signature of Witness ***(required)***	Print Name	Date of Signature

Bienville Building ▪ 628 N. 4th Street ▪ P.O. Box 3117 ▪ Baton Rouge, Louisiana 70821-3117
Phone #: 225/342-0095 ▪ Fax #: 225/342-8823 ▪ *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

Informed Consent to Participate in the
Louisiana Money Follows the Person (MFP) Rebalancing Demonstration

LEGALLY AUTHORIZED REPRESENTATIVE SUPPORT FORM

Purpose:

This form is intended to verify that family members and guardians with decision-making power have discussed moving through the Demonstration program with the participant (your family member or friend in the institution), other family members/ friends, facility staff, DHH staff, or others.

It is very important that the decision to move from a nursing facility or ICF/DD is made mutually, with you and the participant who is using Medicaid services.

It is also important that you have a full understanding of what will happen during the move planning, the actual move, and after the move. As the official decision-maker, you have a role in helping to plan for services, approving the plan, and being available for important decisions after the move.

Please take a few minutes to answer the questions below. It will help us to provide you with the support you may need as a legally authorized representative for a person participating in the demonstration.

Print Your Name:_____ Signature _____

You represent: _____ Date _____

1. Have you discussed moving from the institution (transition) **before** hearing about the demonstration? YES / NO Who did you talk to about moving? _____

2. Have you discussed moving (transitioning) **using the demonstration** with:

A. The participant (your family member or friend in the institution)	YES / NO
B. Other family members/ friends	YES / NO
C. Facility staff	YES / NO
D. The Ombudsman	YES / NO
E. OCDD staff	YES / NO
F. OAAS staff	YES / NO
G. Other DHH staff	YES / NO
H. Someone else:_____	YES / NO

3. How often do you touch base with your family member or friend in the institution?
❑once a week ❑at least once every three months ❑at least once a year
❑at least once a month ❑at least once every six months ❑don't have contact

4. When was the last time you spoke to or visited your family member or friend? (Give an approximate date, time, or event you may have attended.) _____

5. Are there any barriers that keep you from touching base? (Examples: long distance phone calling, no transportation, too far to travel, your health) _____

_____

Complete this form and within one business day fax a copy (225.342.8823) and mail the original to
Faimon Roberts, My Place Program Manager, DHH-OCDD, P.O. Box 3117, Bin #21, Baton Rouge, LA 70821

OCDD/My Place: Request to Assign

Children's Choice (CC), Residential Options Waiver (ROW), or New Opportunities Waiver - Developmental Centers (NOW DC)

My Place Participant --MFP Demonstration

Full Facility Name:	Facility Address –street/ city/ zip code:	
Individual's Name:	Facility Phone #:	Regional Administrative Unit:
Social Security Number:	RAU Staff Name/ Title Completing Form:	
Date of Birth:	RAU Staff Phone and Fax Numbers: ( ) Phone /Fax	
OCDD Waiver Type: ☐ Children's Choice ☐ ROW ☐ NOW	RAU Staff E-Mail Address:	

Legal Status: (If other than Competent Major or child under 18 with parent, appropriate forms must be attached)

- ☐ Competent Major ☐ Interdicted (copy of Legal Document enclosed for adults)
- ☐ Authorized Representative (Notarized OCDD-AR-100 attached)
- ☐ In DHH Custody (Copy of the Court Order/Commitment Papers)

Person Legally Responsible to sign and act on the individual's behalf::_____

- ☐ Minor (Signature of the Legally Authorized Representative required below)

Name	Signature:
Address:	
Office Phone #	Fax #:
Cell Phone #	Home Phone #:

DHH Regional Administrative Unit in which Individual will reside after discharge:

Date of Request by Applicant:	MFP Program Manager Approval (Sign and Date)

Date Received by SRI:

SRI Approval:

Signature Date

SRI:

FOC Sent:_____ Date FOC Received:_____ Date

Linked to Case Management:_____ Date

My Place Participant -- MFP Demonstration

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
BIENVILLE BLDG. 628 N. 4TH STREET/P.O. Box 3117 • BATON ROUGE, LOUISIANA 70821-3117
PHONE #: 225/342-0095 • FAX #: 225/342-8823
"AN EQUAL OPPORTUNITY EMPLOYER"

My Place Louisiana

INDIVIDUAL REVIEW

For Persons Transitioning From Private and Public Facilities

Participant Name: _____ Date: _____/_____/_____

Person completing this form **Name:** _____
Facility Name: _____
Phone: _____
Email: _____

Purpose: My Place LA (MFP Rebalancing Demonstration) is a Medicaid demonstration with mandated components. To help ensure that these components can be met, an individual review of all persons interested in using My Place will be conducted by the My Place Program Manager and Transition/Quality Management Coordinator(s). This review is completed as part of eligibility determination for the demonstration program. The review is intended to identify people who may not meet demonstration participation expectations and/or who may need special focus and support in the transition planning phase.

The outcome of this review is in no way associated with determination of eligibility for waiver services.

Instructions: Confer with the participant's Interdisciplinary Team to determine accurate responses to the questions below. Complete the questionnaire by placing a check in the appropriate box. Attach a brief explanation for any YES responses. Completion of the Individual Review does not impact the person's waiver status. Responding to a waiver offer is a separate activity. You must assist the participant to return waiver offer acceptance paperwork to the appropriate address.

Answer the following by placing a check in the appropriate box:

YES	NO	QUESTION:
		Is the person moving to waiver services only because a judge ordered the transition?
		Is a judge involved in writing, developing, implementing, or monitoring the person's plan of care? For example, does a judge require regular (monthly, quarterly, semi-annual) reports on the person's status?
		Does the person have pending legal charges? If yes, what kind: ☐ Felony ☐ Misdemeanor
		Is the person's family, legal guardian, advocate, or attorney driving the transition request, rather than the referral being made by the facility treatment team based upon the person's progress, health, safety, and stability?
		Is the person requesting to move back to a situation that the facility treatment team feels is potentially dangerous or might not contain the supports needed?
		Is the person requesting to move back to the exact same situation that resulted in his/her being referred for Support and Service Center admission?

Return the completed form and brief explanation of YES responses to: Faimon Roberts, My Place Program Manager; FAX: 225-342-8823 or Email: Faimon.Roberts@la.gov or Keith Bailey: P 318-264-8702 or Email Keith.Bailey@cox.net

Decision _____ Signature _____Date _____

DEPARTMENT OF HEALTH AND HOSPITALS

Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

❒ **TO RELEASE Information TO** **OR** ❒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action ❒ Changing Physicians
❒ Research related treatment ❒ Creating health information for disclosure to a third party.
❒ Other: (Specify)_____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)

❒ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

❒ Alcoholism ❒ Drug Abuse ❒ Mental Health ❒Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness *(If signed with an "X" or mark)* Date

For DHH Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date